| Concealed or denied pregnancy UHL Maternity services | University Hospitals of Leicester NHS NHS Trust<br>Trust ref: C30/2018 |
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## 1. Introduction and Who Guideline applies to

This guideline applies to all members of medical, midwifery and nursing staff within the Maternity Services (including all areas: Maternity). This document aims to support midwifery staff in caring for and assessing women and people who have concealed or denied a pregnancy.

**Related Guidelines:**
Teenage Pregnancy UHL Obstetric Guideline.pdf
Safeguarding in Maternity UHL Obstetric Guideline.pdf
Pregnant Women with a Learning Disability UHL Obstetric Guideline.pdf
Substance Misuse in Pregnancy UHL Obstetric Guideline.pdf
Domestic Violence Abuse in Maternity UHL Obstetric Guideline.pdf
Mental Health Antenatal and Postnatal UHL Obstetric Guideline.pdf
Booking Bloods and Urine Test UHL Obstetric Guideline.pdf

**Background:**
When a woman or person conceals a pregnancy they have, at some point realised that they are pregnant but then make a conscious decision to not share this information with a professional. A denied pregnancy is when a woman or person is unaware of, or unable to acknowledge the existence of their pregnancy. Physical changes to the pregnant woman or person's body may not be present or misinterpreted. The pregnant woman or person may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. Research suggests that pregnant women and people may be in denial of their pregnancy because of poor mental health, substance misuse or a result of a loss of a child (Spinelli, 2005).
Inattentiveness to bodily cues, intense psychological conflicts about the pregnancy and an overall absence of many physical symptoms of pregnancy, led Spielvogel (1995) to believe that even the most well - adjusted woman or person can deny pregnancy.

Some pregnant women or people may appear to have been unaware of their pregnancy until the unexpected arrival of a baby, but adjust quickly and can parent safely and effectively. However, there are significant risks associated with concealed and denied pregnancies, which cannot always be distinguished. It is paramount that a comprehensive assessment takes place and support is offered.

- Pregnancy may be concealed deliberately because agencies already have concerns about the safety of the new-born in the care of parents, and concealment is part of a deliberate effort to prevent removal of the baby.
- Teenagers may conceal or deny a pregnancy because of fear of parental and wider social responses.
- For some, pregnancy outside marriage may carry stigma or even safety risk and is concealed. Collusion from family members to hide the unacceptable pregnancy from the local community or wider family maybe a factor.

- Very vulnerable pregnant women and people, particularly those with learning disabilities, those who have been trafficked or exploited, may not be able to access antenatal care. Consider Joint Agency Response (JAR)
- Pregnant women and people may conceal when there have been interfamilial relationships (incest) or following extramarital affairs.
- If the pregnant woman or person is in a violent relationship and the pregnancy is a result of rape, if announced the pregnant woman or person may fear this could lead to further domestic abuse or violence.
- Concealment and denial of pregnancy may be linked to mental health, neurodiversity, learning difficulties, and more broadly may reflect ambivalence to the pregnancy, and a potential future difficulty in prioritising the baby's needs, or in bonding with the baby.

Nationally, there have been a number of serious case reviews where the baby has been killed following birth. There have been other cases where babies have later been significantly neglected or physically harmed following concealed pregnancy (Northamptonshire Children safeguarding children board, 2016).

## 2. Guideline Standards and Procedures

### 2.1 Antenatal Care (late booking after 24 weeks gestation in accordance with LSCPB procedures).

Follow the NICE antenatal guidelines and in addition:

The booking appointment should be completed by the community or hospital midwife at the earliest convenience to ensure engagement. The Midwife should explore the reasoning behind the late presentation. Careful assessment of family history and functioning is required to identify capacity to parent safely. The booking appointment is to include routine antenatal screening being offered to the pregnant woman or person. A follow-up appointment should be made, if possible within two weeks of the booking appointment. If the booking appointment is completed in hospital the community team MUST be notified.
The Midwife should liaise with relevant professionals who are currently or have previously been involved with the pregnant woman or person, to support and identify safeguarding or health risks.

- Any pregnant woman or person under the age of 19 with a concealed or denied pregnancy should have a Maternity Safeguarding referral on ICE completed; this will then be discussed at the specialist midwife meeting and allocated to a teenage specialist midwife if required.
- If there is establishment of a learning disability or difficulty the midwife should identify how this impacts on them as an individual and consider if further support would be needed. Explore the support network of the pregnant woman or person to include, partner and close family. Do not assume their understanding and ascertain whether they have mental capacity.
- More frequent visits may be required by the allocated community midwife, if there is resource availability, possibly visiting the pregnant woman or person at home in order to give support.
- Signposting and encouragement for parenting education involving those close to the pregnant woman or person should be given to increase their support.
- The LSCPB Maternity Safeguarding referral on ICE should be completed; following consent, with the outcome of the midwife's safeguarding assessment. The referral

form should be placed in the hospital notes. At this point in relation to the late booking, unless other safeguarding risks are identified the referral would be taken for information only, community midwife to monitor and re-refer if the pregnant woman or person disengages from care. The safeguarding team will inform the health visitor and GP when the referral is received.
- The midwife should attend any Child protection meetings relating to the unborn and inform the Safeguarding Midwife of the outcome.

### 2.2 Post-delivery care of the pregnant woman or person with a concealed or denied pregnancy where there has been no antenatal care (See appendix one).

At the earliest convenience the midwife should discuss with the pregnant woman or person why they had not sought antenatal care. National alerts from other areas should be checked by delivery suite co-ordinator (CP – IS check. See Appendix 1). A safeguarding assessment should follow to include consideration of the following:

- Learning difficulties
- Neurodiversity
- Mental health issues.
- Learning disability
- Drug and alcohol misuse
- Homelessness and issues with housing
- Domestic abuse- Consider relationship status and current situation with father of baby which could include non-consensual sex/ rape.
- Interfamilial relationships (incest)
- PTSD- traumatic loss of previous child or children. This could be by death or removal by local authority.
- Cultural issues- which could include sex outside of marriage.
- Threat of honour based violence.
- Trafficking
- Sex working
- Teenage pregnancy
- Child Sexual Exploitation
- Poverty- no access to benefits or funding for healthcare (recently integrated into the UK).
- Access to health issues, to include non-English speaking.

- Safeguarding referral should be made immediately and called through to social care (the midwife should complete the LSCPB Maternity Safeguarding referral on ICE and email through to safeguarding team, documenting the name of the social worker they have spoken with in box 23). The Safeguarding team should be informed, who will request a strategy meeting with social care in line with the LSCB procedures. If out of office hours and/or the safeguarding team are not available the pregnant woman or person should be advised to stay in hospital until this is completed.
- Parenting logs should be commenced, to include parental bonding and interaction with the baby.
- Discuss with neonatal team regarding the need for newborn observations
- Consideration for perinatal mental health referral for review.
- If the woman or person wishes to self-discharge, the midwife should discuss this with them and ascertain the reason why they want to self-discharge. Social care must be called if the strategy meeting has not taken place and establish a plan.
- On discharge the midwife must ensure that the community team are informed via E3 documentation.

## 3. Education and Training

Safeguarding training is included in the annual saving babies lives mandatory training

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
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| Completion of A Form to notify safeguarding team for all concealed or denied pregnancies | Audit | Safeguarding Lead | | |

## 5. Supporting References


CEMACH (2007). Saving Mother's Lives: Reviewing maternal deaths to make motherhood safer - 2003-2005. [online] London: CEMACH, p.2. Available at: http://www.publichealth.hscni.net/sites/default/files/Saving%20Mothers%27%20Lives%202003-05%20.pdf [Accessed 15 Feb. 2018].

MBRRACE 2022 https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/#causes-of-death

Leicester Safeguarding Children Board (2014). Concealment and Denial of Pregnancy. Leicester City Leicestershire and Rutland: LSCB. Available at:

Spielvogel AM, (1995). Denial of pregnancy: a review and case reports. Birth22(4):220-226

LSCPB Safeguarding children online: concealed_preg.pdf (proceduresonline.com)


## 6. Key Words

Concealed pregnancy, denied pregnancy, hidden pregnancy, safeguarding in maternity

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**The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.**
**As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.**

| CONTACT AND REVIEW DETAILS | |
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| Author: Rheo Smith and Clare Robinson<br>**Guideline Lead (Name and Title)**<br>Clare Robinson – Safeguarding Midwife | **Executive Lead**<br>Chief Nurse |
| **Details of Changes made during review:**<br>Risk assessment should also consider neurodiversity, and those with learning disabilities. Consider joint agency response.<br>Added to discuss with the neonatal team regarding the need for newborn observations.<br>**October 2024**<br>Replaced all references to A Form with 'Maternity Safeguarding referral on ICE'<br>Added LSCPB to reference list | |

## Appendix 1: Child Protection Information Sharing (CP-IS) Operational Guidance

All pregnant women and people who are unbooked to UHL, to include denied or concealed pregnancy.